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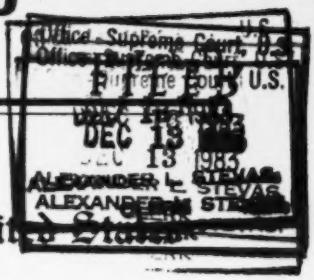

In the
Supreme Court of the United States

OCTOBER TERM, 1983

HOSPITAL SERVICE ASSOCIATION
OF NEW ORLEANS, INC.

Petitioner,

VERSUS

ST. BERNARD GENERAL HOSPITAL, INC.

Respondent.

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

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QUESTIONS PRESENTED

Petitioner, Hospital Service Association of New Orleans, Inc. ("Blue Cross") and respondent, St. Bernard General Hospital, Inc. ("St. Bernard") executed a written contract (sometimes referred to herein as a "provider agreement") on July 1, 1961, pursuant to which St. Bernard agreed to provide hospital services to Blue Cross policyholders and Blue Cross, in turn, agreed to pay directly to St. Bernard its billed charges for furnishing covered policy benefits to these policyholders. The ultimate amount payable to St. Bernard was determined by a reimbursement formula in the contract which provided that St. Bernard would be paid 100% of its billed charges for covered policy benefits but not to exceed the average per diem payment or the average per case payment, whichever was less, made by Blue Cross to certain participating hospitals in the New Orleans area. The participating hospitals used in the formula calculation were all relatively large, non-profit, fully accredited, community hospitals which also had contracts with Blue Cross.

The district court rejected respondent's claims under section 1 of the Sherman Act (15 U.S.C. § 1) holding that the method of reimbursement under the provider agreement was a reasonable business practice having only pro-competitive effects. The Fifth Circuit, in reversing the judgment of the district court, remanded the case on the basis that respondent had made a *prima facie* showing of a *per se* price fixing violation and that the evidence supported "the possibility" of a refusal to deal claim under Section 1 of the Sherman Act. The questions presented by the Fifth Circuit's decision are:

1. Should the provider agreement between St. Bernard and Blue Cross be classified as an agreement to fix prices

for purposes of antitrust analysis under Section 1 of the Sherman Act?

2. Does the fact that a majority of the persons serving on the Board of Managers of Blue Cross were appointed by the participating hospitals, without evidence of anything more, transform the payment provision of the provider agreement into an unlawful horizontal agreement to fix prices under Section 1 of the Sherman Act?

3. Does the fact that a majority of the persons serving on the Board of Managers of Blue Cross were appointed by the participating hospitals, without evidence of anything more, transform the decision of Blue Cross not to deal with St. Bernard on terms identical to those accorded to the participating hospitals into an unlawful concerted refusal to deal under Section 1 of the Sherman Act?

4. Should the provider agreement between St. Bernard and Blue Cross in the circumstances described above be judged under the *per se* rule or the rule of reason under the antitrust laws?

5. Considering that the district court, on the trial of the merits, dismissed St. Bernard's claim at the close of the plaintiff's evidence under Rule 41(b) of the Federal Rules of Civil Procedure, did the Fifth Circuit err in remanding the case to the district court on the basis that St. Bernard had made a *prima facie* showing of a *per se* price fixing violation and that the evidence supported "the possibility" of a refusal to deal claim under Section 1 of the Sherman Act?

RULE 28.1 STATEMENT

Prior to January 1, 1975 Hospital Service Association of New Orleans, Inc. was the Louisiana non-profit mutual insurance company which offered the Blue Cross plan in the New Orleans area. On January 1, 1975 a consolidation occurred involving Hospital Service Association of New Orleans, Inc. and Louisiana Hospital Service, Inc. The corporate name of the surviving company is Louisiana Health Service and Indemnity Company. This company operates under the trade name Blue Cross of Louisiana and offers the Blue Cross plan throughout the State of Louisiana. For convenience of the litigation the name Hospital Service Association of New Orleans, Inc. has been carried forward as the reference to the defendant pursuant to Rule 25(c) of the Federal Rules of Civil Procedure.

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Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Petitioner, Hospital Service Association of New Orleans, Inc. ("Blue Cross"), respectfully prays that a Writ of Certiorari issue to review the judgment of the Court of Appeals for the Fifth Circuit entered on August 22, 1983.

OPINIONS BELOW

The opinion of the court of appeals is reported at 712 F.2d 978 (1983). The order of the court of appeals dated October 3, 1983 denying a petition for rehearing is not reported. The opinion of the district court rendered on December 21, 1981 is not reported. These opinions are reprinted in the Appendix to this Petition.

JURISDICTION

The judgment of the court of appeals was entered on August 22, 1983. A timely petition for rehearing was denied on October 3, 1983. This Court has jurisdiction to review the judgment of the court of appeals pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1 (1982), provides in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal....

STATEMENT OF THE CASE

The Parties

Petitioner, Blue Cross, was at all times material herein a Louisiana non-profit mutual insurance company. As a mutual insurance company it is subject to regulation by the Insurance Commissioner of the State of Louisiana under applicable provisions of the Louisiana Insurance Code. La. Rev. Stat. Ann. §§ 22:1-1912 (West 1959, West 1978 and West Supps. 1983). In addition, because of its non-profit status and its contractual relationships with hospitals organized on a non-profit basis, Blue Cross is deemed to be a beneficial institution exempt from certain forms of taxation by the State of Louisiana. La. Rev. Stat. Ann. §§ 22:1661-63 (West 1978).

Respondent, St. Bernard, was a Louisiana for-profit corporation which at all times material herein operated a thirty-nine bed hospital in Chalmette, Louisiana. The principal stockholder and controlling person was Dr. Emile A. Bertucci, Jr. In addition, the real estate, the building and all of the equipment utilized by St. Bernard were owned individually by Dr. Bertucci and leased by him to St. Bernard. The building occupied by St. Bernard was also occupied by St. Bernard Medical Clinic, a clinic individually owned and operated by Dr. Bertucci. (Supp. Rec., Tr. 80-82, 114, 122-24).

Course of the Proceedings and Disposition in the Courts Below

St. Bernard instituted this action in September of 1971 alleging a violation of the Sherman Act. Although the original complaint, even as amended in June of 1977, does not specify the particular section of the Act under which St. Bernard claims relief, the case proceeded only under Section 1 of the Sherman Act. 712 F.2d at 987 n. 15. St. Bernard contended at trial and on appeal that Blue Cross, in combination with nine "participating" hospitals, discriminated against it by refusing to pay it on the same basis as the participating hospitals. St. Bernard also contended that the terms of the provider agreement under which it was paid constituted price fixing.

The case was tried on the merits without a jury on December 21, 1981 before the late Honorable Jack M. Gordon, District Judge. At the conclusion of the presentation of evidence by plaintiff, the district court granted petitioner's motion for involuntary dismissal under Rule 41(b) of the Federal Rules of Civil Procedure. The trial judge held that there was not a scintilla of evidence of any coercion on

the part of Blue Cross; that there was no evidence of any anticompetitive motive on the part of Blue Cross; that there was no injury shown to competition; and that the reimbursement formula in the St. Bernard contract was entirely reasonable, appropriate and proper. (Supp. Rec., Tr. 188-202).

The Fifth Circuit reversed and remanded the case on the basis that St. Bernard had made a *prima facie* showing of a *per se* price fixing violation and that the evidence supported the "possibility" of a refusal to deal claim under Section 1 of the Sherman Act. 712 F.2d at 987, 983. The evidence relied upon by the Fifth Circuit to support its reversal and remand of the case showed only that Blue Cross would not deal with St. Bernard on the same contractual basis as the nine participating hospitals and that the participating hospitals each appointed two persons to serve on the Blue Cross Board of Managers.

Statement of Facts Relevant to the Questions Presented for Review

For the most part, these facts are set forth in a comprehensive stipulation presented to the district court at the beginning of the trial on December 21, 1981. (Statement of Uncontested Facts, Supp. Rec., Tr. 9-16).

Prior to January 1, 1975, the time period relevant to this litigation, Hospital Service Association of New Orleans, Inc. was licensed to use the Blue Cross name and symbol in connection with the marketing of health insurance only in a five parish (county) area which essentially comprised the greater New Orleans metropolitan area.

Blue Cross was organized in 1934 by four non-profit

community hospitals in the New Orleans area. Eventually, five other non-profit hospitals in Blue Cross' service area signed contracts to become "participating" members.

In order to become a participating hospital, the hospital, *inter alia*, had to be (1) non-profit; (2) accredited by the Joint Commission on Accreditation of Hospitals; and (3) function as a community oriented hospital, *i.e.*, one having a broad interest in the general welfare of the community. The participating hospital was required to sign a written contract which obligated it to provide goods and services to Blue Cross policyholders for a contract term of one year. In addition, the participating hospital agreed to underwrite the cost of the goods and services furnished to Blue Cross policyholders in the event the reserves of Blue Cross became inadequate. Blue Cross agreed to pay directly to the hospital its regular charges for the covered benefits furnished to Blue Cross policyholders during the contract term. (Supp. Rec., Tr. 72-74).

During the time relevant to this litigation, each of the nine participating hospitals designated two persons (Blue Cross policyholders) to serve on the Board of Managers of Blue Cross. These Board members, in turn, elected the other members at large to the Board at the annual meeting. During the time relevant to this litigation the Board consisted, on the average, of thirty-one members. Nine members were hospital administrators associated with the participating hospitals and the balance of the Board was made up of business, professional and civic leaders from the New Orleans area. (DX 2 and Supp. Rec., Tr. 63-71).

Blue Cross also contracted with other hospitals in its service area which were designated as "contracting

hospitals". The contracting hospital was usually a proprietary hospital organized for profit, not fully accredited, and/or not one deemed to be community oriented. The contracting hospital was not entitled to designate persons to serve on the Board of Managers of Blue Cross. (Supp. Rec., Tr. 72-74). During the time relevant to this litigation there were ten contracting hospitals, including St. Bernard.

The "contracting" provider agreement obligated the hospital to provide goods and services to Blue Cross policyholders. Unlike the participating agreement, however, this contract could be cancelled on 30 days notice by either party (which in effect only obligated the contracting hospital to Blue Cross for 30 days) and did not obligate the hospital to underwrite the cost of furnishing goods and services to Blue Cross policyholders in the event Blue Cross' reserves became inadequate. Subject to certain limitations, Blue Cross agreed to pay directly to the hospital its regular charges for covered benefits furnished to Blue Cross policyholders.

By letter dated February 13, 1960, Dr. Bertucci requested that Blue Cross enter into a contractual arrangement with St. Bernard. (DX 4). The first contract between St. Bernard and Blue Cross was dated March 31, 1960. (DX 6). This contract provided in pertinent part for payment by Blue Cross of 97% of St. Bernard's regular charges for all covered services rendered to Blue Cross policyholders. The original contract was replaced by a new agreement dated July 1, 1961. (DX 8). This contract provided in pertinent part for payment by Blue Cross of 98% of St. Bernard's regular charges for all covered in-patient services furnished to Blue Cross policyholders. However, this payment was conditioned by the stipulation that the total payments would not exceed 98% of the average per diem payment

made by Blue Cross to the participating hospitals, or 98% of the average payment per case made by Blue Cross to the participating hospitals, whichever was less.

The July 1, 1961 contract was amended by letter dated December 6, 1961 to provide that the averages computed under the formula would take into account payments under specific types of Blue Cross insurance policies rather than the average of payments made under all insurance contracts with policyholders. The July 1, 1961 contract was further amended by letter agreement dated March 29, 1962 (DX 10), to provide that St. Bernard would receive 100% of billed charges, but not to exceed the average per diem payment or the average per case payment made to the participating hospitals, whichever was less. Furthermore, these calculations under the amended contract were computed on a quarterly and annual basis, and the basis more favorable to the hospital was used.

Under the contracting agreement, as amended, Blue Cross paid St. Bernard 100% of billed and covered charges throughout the calendar year. At the end of the year, however, if the total amount already paid to St. Bernard exceeded the formula averages, St. Bernard was required to pay the excess back to Blue Cross. The formula in the contracting agreement determined only the total or aggregate amount that Blue Cross paid St. Bernard for services provided to all Blue Cross patients (having particular types of insurance policies) over the course of the entire calendar year. Moreover, the formula did not focus only on charges. To the contrary, it had both *charge* and *quantity* components. Thus, the reimbursement formula did not fix or set the specific rates or charges of St. Bernard to a particular patient for any particular service.[1]

[1] To the extent that charges were not covered by the Blue Cross

In calendar years 1966, 1969, 1970, 1971 and 1972 St. Bernard exceeded the average under the contract formula and paid back to Blue Cross varying amounts, from a low of $843.04 to a high of $51,187.60. 712 F.2d at 983 n. 9. In all other years between 1962 and time of trial, St. Bernard did not exceed the averages computed under the formula and was paid 100% of all charges for covered services furnished to Blue Cross policyholders.[2]

REASONS FOR GRANTING THE WRIT

The dramatic escalation in the cost of health care during the last twenty years is well known. The Blue Cross plan in the New Orleans area during this time was designed to provide prepaid hospital service benefits to policyholders at the lowest cost obtainable. The contractual agreements with hospitals facilitated this objective. The decision of the court of appeals reversing and remanding this case on the basis that St. Bernard had made a *prima facie* showing of a *per se* price fixing violation under Section 1 of the Sherman Act raises serious questions of public importance in the health care and health insurance industry. This decision casts doubt upon the validity of

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(Footnote 1 continued)
plan, *e.g.*, co-pays and deductibles, they remained the responsibility of the patient. St. Bernard always set its own rates for room, board and ancillary services and these rates were the same for all patients, regardless of whether the patient was insured by Blue Cross or some other plan or form of insurance. (Supp. Rec., Tr. 147, 162). There is no evidence or contention that the rates charged by St. Bernard or other contracting hospitals were not unilaterally determined.

[2] It is important to note that a contracting hospital could actually charge less than the participating hospitals for room and ancillary services and still exceed the average under the reimbursement formula if it exceeded the average length of stay on a cost per case comparison with the participating hospitals. St. Bernard exceeded the average length of stay in 1969-1972. (Supp. Rec., Tr. 92-93, 112).

every provider agreement where common business interests exist between a health care provider and the third party payor.[3]

The underlying premise of the Fifth Circuit's decision is that Blue Cross is an association of nine hospitals solely because each appointed two persons to the Blue Cross Board of Managers. From there the court makes an inferential leap to find *prima facie* evidence of a *per se* price fixing violation without any explanation of what price was "fixed". No court has ever reached this conclusion before. This represents a clear departure from principles of antitrust law established by this Court with regard to (1) the definition of price fixing; (2) proof of concerted behavior; and (3) the circumstances under which the *per se* rule should be applied under Section 1 of the Sherman Act. The decision is also inconsistent with the decisions of other courts of appeals which have considered and rejected similar claims involving provider agreements and the applicability of a *per se* rule.

I. THERE IS NO BASIS IN FACT OR IN LAW FOR THE FIFTH CIRCUIT'S FINDING THAT ST. BERNARD HAS MADE A *PRIMA FACIE* SHOWING OF A *PER SE* PRICE FIXING VIOLATION.

The Fifth Circuit began its analysis of the price

[3] The Fifth Circuit noted in its opinion that other contracting hospitals in New Orleans have filed suit against Blue Cross charging similar antitrust violations. The decision of the Fifth Circuit offers no guidance to the district judge or to the litigants and will only serve to cause confusion as to the proper antitrust analysis to be used, not only in this case, but in the other pending litigation. Pretermitting the fact that single damages are claimed in those cases in excess of $6 million dollars, this Court should grant review to prevent an improvident application of a *per se* rule.

fixing claim by stating that St. Bernard's evidence was relatively simple to describe. 712 F.2d at 985. Indeed, all that St. Bernard presented was evidence that Blue Cross did not deal with St. Bernard on terms identical to the participating hospitals; that Blue Cross would not admit St. Bernard to participating hospital status; and that the nine participating hospitals each appointed two persons to the Board of Blue Cross. The court of appeals then assumed, without any evidence to support the fact, that the participating hospitals controlled Blue Cross. *Id.* From this, the court concluded that St. Bernard had made a *prima facie* showing of a *per se* price fixing violation. *Id.* at 987. The court never explains, however, what price was fixed or how it was fixed.

Before any business behavior can be classified as *per se* unlawful it must be clear based on experience and economic analysis that the conduct under review is so harmful and so lacking in redeeming virtue that it should be categorically prohibited. This principle has been recognized time and time again by this Court. *Northern Pacific Railway Co. v. United States,* 356 U.S. 1 (1958); *White Motor Co. v. United States,* 372 U.S. 253 (1963); *Continental T.V., Inc. v. GTE Sylvania, Inc.,* 433 U.S. 36 (1977); *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.,* 441 U.S. 1 (1979).

The threshold question in determining whether to classify a practice as *per se* illegal is whether the Court has sufficient information about "the actual impact of these arrangements on competition to decide whether they have such a 'pernicious effect on competition and lack...any redeeming virtue'...." *White Motor Co. v. United States,* 372 U.S. 253, 263 (1963) (quoting *Northern Pacific Railway Co. v. United States,* 356 U.S. 1, 5 (1958)).

This Court elaborated on the foregoing principle in *Broadcast Music:*

> To the Court of Appeals and CBS, the blanket license involves 'price fixing' in the literal sense: the composers and publishing houses have joined together into an organization that sets its price for the blanket license it sells. But this is not a question simply of determining whether two or more potential competitors have literally 'fixed' a 'price'. *As generally used in the antitrust field, 'price fixing' is a shorthand way of describing certain categories of business behavior to which the per se rule has been held applicable. The Court of Appeals' literal approach does not alone establish that this particular practice is one of those types or that it is 'plainly anticompetitive' and very likely without 'redeeming virtue'.* Literalness is overly simplistic and often overbroad. When two partners set the price of their goods or services they are 'literally price fixing', but they are not *per se* in violation of the Sherman Act....
>
> Consequently,...'[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations. ...'

441 U.S. at 8-9 (footnote and citations omitted) (emphasis added).

Obviously, any horizontal agreement among competitors formed for the purpose and with the effect of raising, depressing or fixing the price of a commodity to be charged to consumers is *per se* unlawful. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982). However, it is equally clear that Blue Cross' conduct does not fit into any category of business behavior to which the

per se price fixing rule has been held applicable. The court of appeals' hasty application of a *per se* rule, instead of the more traditional rule of reason, is totally inappropriate where, as here, the alleged conduct did not have the effect of raising, depressing or fixing the price of a commodity and was not shown to be manifestly anticompetitive or so plainly anticompetitive that no elaborate study of the industry is needed to establish its illegality.[4] The agreement between Blue Cross and St. Bernard containing the reimbursement formula was not shown to have an adverse effect on competition in any market and there was absolutely no evidence that the delivery of health care services to the public by hospitals in the New Orleans area was in any way impaired by the manner in which Blue Cross contracted with hospitals in that market.

A. The Provider Agreement Does Not Fix Prices.

Blue Cross is a non-profit mutual insurance company. In its relationship with hospitals, including St. Bernard, Blue Cross is a purchaser of services for the benefit of its policyholders. Provider agreements such as the contract here involved have consistently been viewed as contracts "for the purchase of goods and services." *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979); *St. Bernard General Hospital, Inc. v. Hospital Service Association of New Orleans, Inc.*, 618 F.2d 1140, 1145 (5th Cir. 1980). This buyer-seller relationship is

[4] The market for hospital services is imperfect in the sense that patients do not as a general rule select hospitals. Doctors having staff privileges have the authority to admit patients and the power to influence the selection of a hospital for their patients. Thus, "classic marketplace forces" are not present in the health care industry. *See National Gerimedical Hospital & Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 386 n. 10 (1981).

simply a vertical arrangement. Indeed, the court of appeals recognized that there was a vertical link between St. Bernard, the supplier, and Blue Cross, the customer. 712 F.2d at 986.

Provider agreements have not been deemed price fixing because they do not establish prices to be charged to third parties, the *sine qua non* of price fixing. This has been the result reached by every court which has considered the matter under similar circumstances. *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502, 505 (2d Cir. 1982); *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 544 F.Supp. 230 (N.D. Cal. 1981), *aff'd per curiam*, 677 F.2d 47 (9th Cir.), *cert. denied*, __ U.S. __, 103 S.Ct. 376 (1982); *Proctor v. State Farm Mutual Automobile Ins. Co.*, 675 F.2d 308, 337 (D.C. Cir.), *cert. denied*, __ U.S. __, 103 S.Ct. 86 (1982); *Glen Eden Hospital, Inc. v. Blue Cross & Blue Shield of Michigan*, 555 F.Supp. 337 (E.D. Mich. 1983); *Feldman v. Health Care Service Corp.*, 562 F.Supp. 941 (N.D. Ill. 1982).

The analysis employed by the district court in *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.* is typical of those cases rejecting price fixing claims:

> Plaintiffs assert alternatively that the agreements are *per se* illegal as a form of maximum resale price maintenance....This argument, though facially more plausible, is none the less unavailing....[T]he pharmacy agreements differ in several important respects from the typical agreement between a manufacturer and a distributor establishing resale prices; most significantly, under the pharmacy agreements, there is no resale of anything....The only price that is

> established by the pharmacy agreement is the price that Blue Cross will pay participating pharmacies for prescribed drugs. 'The price-fixing within the scope of the *per se* prohibition of § 1, however, is an agreement to fix the price to be charged in transactions with third parties, not between the contracting parties themselves.' *Sitkin Smelting & Refining Co. v. FMC Corp.*, 575 F.2d 440, 446 (3d Cir.), *cert. denied*, 439 U.S. 866, 99 S.Ct. 191, 58 L.Ed.2d 176 (1978).

518 F.Supp. 1100, 1106 (D.Conn. 1981), *aff'd per curiam*, 675 F.2d 502 (2d Cir. 1982) (citations omitted).

The formula contained in the contracting provider agreement in this case does not fix prices. Indeed, St. Bernard determined the prices it charged patients for its services. The formula determined only the total or aggregate amount that Blue Cross paid to St. Bernard for covered services furnished to all Blue Cross patients (having particular types of insurance policies) over the course of an entire calendar year. Moreover, the formula did not focus only on charges. To the contrary, it had both charge and quantity components.

The formula provided, as the district court held, a reasonable basis for reimbursement to St. Bernard under the circumstances of this case. There is simply no basis to include the contractual agreement between Blue Cross and St. Bernard in that category of business behavior to which the *per se* rule has heretofore been held applicable. To do so would represent a clear departure from the principles established by this Court and would, in effect, create a new category of *per se* unlawful conduct.

B. There Was No Concerted Activity

The Fifth Circuit, in its overview of the facts, observed that the participating hospitals enjoyed "effective control" of the Blue Cross Board by appointing a simple majority on the Board who, in turn, selected the remaining directors. 712 F.2d at 981. The fact that each participating hospital appointed two persons to serve on the Blue Cross Board does not establish, without additional supporting evidence, that the hospitals controlled the business affairs of Blue Cross. *Krivo Industrial Supply Co. v. National Distillers and Chemical Corp.*, 483 F.2d 1098 (5th Cir. 1973), *modified factually*, 490 F.2d 916 (5th Cir. 1974). The record contains no evidence, much less a *prima facie* showing, that the participating hospitals controlled the day-to-day business affairs of Blue Cross or that Blue Cross was, as characterized by the court of appeals, "an association comprised of nine local hospitals". *Id.* at 987.

Even if one were to assume that the composition of the Blue Cross Board, alone, was sufficient to constitute *prima facie* evidence of a combination or concert of action between the hospitals and Blue Cross, the other evidence presented at the trial completely rebuts this contention. Yet, the Fifth Circuit failed to even discuss this evidence in its opinion. It concluded *solely* on the basis of the composition of the Blue Cross Board that the hospitals controlled Blue Cross. 712 F.2d at 978.

The former president of Blue Cross testified that Blue Cross was run as an independent corporation by a management group, executives and staff. Of the thirty-one members of the Board of Managers, nine were hospital administrators appointed by the participating hospitals, nine were responsible citizens in the community also appointed

by the participating hospitals, and the balance of thirteen members were appointed at large by the Board from leaders in the community. (Supp. Rec., Tr. 59-60, 64-69; DX 2, pgs. 3-6). Except for the nine hospital administrators, the Board consisted of professional and civic leaders in the community having no proprietary interest in any hospital or any apparent predisposition against St. Bernard. Blue Cross' former president testified categorically that the participating hospitals did not control the business affairs of the corporation. (Supp. Rec., Tr. 69-71). No employee of a participating hospital ever served as chairman of the Board, president, or vice president of Blue Cross.

St. Bernard presented no evidence that the appointed directors acted as agents of the participating hospitals in discharging their duties on the Blue Cross Board. Moreover, the president and vice presidents in charge of finance, marketing, claims, advertising and hospital relations were all full-time, professional and salaried persons. (Supp. Rec., Tr. 70-71).

The uncontradicted testimony also showed that the reimbursement formula concept here at issue originated with the former executive director of Blue Cross (not a hospital employee) and was recommended to the Board by the Blue Cross staff in 1961. (Supp. Rec., Tr. 76-78). There is simply no evidence that the participating hospitals involved themselves in Blue Cross' business or that they sponsored, designed or in any way used their representation on the Board to promote the reimbursement formula in the contract for any anticompetitive purpose.

The Fifth Circuit did not cite *United States v. Sealy, Inc.*, 388 U.S. 350 (1967). However, *Sealy* is instructive because of its "substance over form" analysis of the

relationship between a corporation and its directors. There this Court concluded on the evidence after trial on the merits that the corporation was a joint venture operated by and for its stockholder-licensees because all of the directors were required to be stockholder-licensees and the directors, in fact, exercised control in the "day-to-day business" of the company including the grant, assignment, reassignment and termination of exclusive territorial licenses, the very activity challenged. This Court concluded that Sealy, Inc. was an instrumentality of the licensees to achieve the challenged horizontal territorial allocation.

Sealy is obviously distinguishable from the case at hand. The distinction, however, lends support to the proposition that the power of appointment to the Blue Cross Board, without more, cannot form the basis of a horizontal agreement between hospitals to violate the Sherman Act.

C. *Maricopa* Does Not Control

The Fifth Circuit noted that counsel for St. Bernard relied heavily on this Court's decision in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), in support of the price fixing contention. After a lengthy discussion of the *Maricopa* case, the Fifth Circuit concluded that it did not control this case because of factual dissimilarities. The court noted that the fee schedule in *Maricopa* was strictly a horizontal restraint created by local physicians. By contrast, St. Bernard, a supplier, charged that Blue Cross, as a customer, combined with the participating hospitals, as suppliers, to prejudice St. Bernard's fiscal interest. The court acknowledged that this charge did not assume a strictly horizontal restraint, but rather included a vertical link from supplier to customer and that these charges "are not so clearly per se violations

of the antitrust laws." 712 F.2d at 986. The court, then chose to ignore these clear factual and legal distinctions, and based its decision to reverse and remand on the "teachings of *Maricopa*":

> The *Maricopa* case, due to these dissimilarities, does not control this case. It is possible, even after *Maricopa*, that a pricing schedule could reflect a legal attempt to establish terms of dealing, rather than an illegal price fixing plan. Yet *Maricopa* does, without question, negate the logic employed in the district court here that a price fixing scheme can be legal if its effects further the public interests. Based on the teachings of *Maricopa*, which was decided after the decision of the district court in this case, we find that the hospital has made a prima facie showing of a per se price fixing violation.

712 F.2d at 987.

Of course, *Maricopa* teaches only that a horizontal agreement among competitors, even doctors, to fix the prices they charge consumers constitutes a *per se* violation regardless of claimed procompetitive benefits. The issue in *Maricopa* was not whether a horizontal price fixing agreement existed among the physicians to establish maximum charges—that was assumed for purposes of summary judgment—but rather whether such arrangement could be justified under a rule of reason analysis. This Court, in *Maricopa*, expressed concern over the fact that the agreement between competing physicians permitted them to sell their services to consumers at fixed prices, and arguably to "affect the prevailing market price for medical care." 457 U.S. at 356. The touchstone of this Court's decision was public injury, *i.e.*, potential injury to consumers as a result

of the pernicious effect of the price fixing agreement on competition.

There is no evidence, or even inference, that the St. Bernard provider agreement affected the price of hospital services at St. Bernard or any other hospital to patients in the New Orleans area or that the formula selected by Blue Cross to reimburse St. Bernard and other contracting hospitals injured competition in any way. The provider agreement between Blue Cross and St. Bernard simply established the total or aggregate dollar amount that Blue Cross paid to St. Bernard for the quantity of services furnished to all Blue Cross policyholders during a calendar year.

The Fifth Circuit's decision presumes without discussion that the district court first concluded that the arrangement by which St. Bernard was reimbursed for services was a "price fixing scheme" and that the district court then attempted to justify the price fixing scheme on the basis that its effects furthered the public interest. 712 F.2d at 987. This was *not* the "logic employed" by the district court. Judge Gordon obviously rejected St. Bernard's price fixing charge altogether. It is clear from the record that Judge Gordon treated this case as essentially involving only an alleged refusal to deal. The district court correctly applied a rule of reason analysis and after finding no coercion, no anticompetitive motive and no injury to competition rejected plaintiff's claim.

D. The *Per Se* Rule Does Not Apply.

Even if the relationship between Blue Cross and the participating hospitals could be deemed to be a combination under Section 1 of the Sherman Act to impose the

reimbursement formula on St. Bernard, there would still be no *prima facie* violation shown. In *Broadcast Music*, this Court held that certain business relationships should only be classified as *per se* unlawful after the courts have had considerable experience with the challenged conduct. 441 U.S. at 9. This Court concluded that although the blanket licensing agreement under consideration in *Broadcast Music* was price fixing in a literal sense, it was more appropriately judged under the rule of reason because it was not a "naked restraint" having no purpose other than to restrict competition and decrease output. *Id.* at 19-20. The reimbursement formula in St. Bernard's contract is not a "naked restraint". The district court, applying a rule of reason analysis, found it to be reasonable under the circumstances of this case and, indeed, procompetitive, in the sense that it provided an incentive for hospitals to contain their costs.

Blue Cross, as a non-profit mutual insurance company, sells a product to the public in the form of a prepaid health insurance plan. This plan guarantees to Blue Cross policyholders that hospital services, to the extent covered by their insurance policies, will be available to them. The provider agreement between Blue Cross and St. Bernard was ancillary to Blue Cross' obligation to its policyholders. This Court has previously recognized that "some type of provider agreement is necessary for a service benefit plan to exist" and that while such agreements are not necessarily the "business of insurance" for purposes of antitrust analysis under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, they do provide a means by which an insurer can satisfy its obligation to its policyholder. *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 213 n. 9 (1979). This Court stated:

> The Pharmacy Agreements thus do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield. By agreeing with pharmacists on the maximum prices it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its policyholders. The Agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the 'business of insurance'.

440 U.S. at 214.

In this very case, another panel of the Fifth Circuit specifically recognized that the provider agreement was the means by which Blue Cross sought to minimize the cost it must incur to fulfill its underwriting obligations. *St. Bernard General Hospital, Inc. v. Hospital Service Association of New Orleans, Inc.*, 618 F.2d 1140, 1145 (5th Cir. 1980).

It is certainly reasonable to assume that a third party payor (Blue Cross) will strive to purchase hospital goods and services on the best and most reasonable terms possible. This principle was recognized by the Third Circuit in *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80, 84 (3rd Cir.), *cert. denied*, 414 U.S. 1093 (1973), *disapproved on other grounds, Group Health & Life Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 1979). The court stated:

> In its negotiating with hospitals, Blue Cross has done no more than conduct its business as every rational enterprise does, i.e., get the best deal possible. This pressure encourages hospitals

> to keep their costs down; and, for its own competitive advantage, Blue Cross passes along the saving thus realized to its consumers.

481 F.2d at 84.

The participating hospitals did not buy hospital services from St. Bernard nor would they, even in the absence of an alleged combination, normally be expected to deal with St. Bernard. The participating hospitals were all sellers of services. Blue Cross, as a buyer of services, is the only entity in the normal distribution chain, a vertical link, who would be expected to buy hospital services from St. Bernard. When Blue Cross enters the market as a buyer of hospital services it is acting on behalf of its policyholders; and not as an agent for the participating hospitals.[5]

In *Broadcast Music* this Court noted that even though ASCAP set the price for its blanket license, that license was quite different from anything any individual copyright owner could issue. 441 U.S. at 22-23. Similarly, the prepaid health insurance plan offered by Blue Cross to its policyholders was quite different from any product which any single hospital could offer. The Blue Cross provider agreement was ancillary to the sale of the Blue Cross prepaid health insurance plan. It is obviously, very different from the health services offered by the hospitals. St. Bernard failed to produce any evidence that the provider agreement injured or was likely to injure competition among hospitals in the New Orleans area. In refusing to

[5] Blue Cross was not, as the Fifth Circuit described it, "an association comprised of nine local hospitals." 712 F.2d at 987. It was, contrary to the Fifth Circuit's view, an individual trader who, without any anticompetitive motive or intent, announced in advance the terms on which it would deal with St. Bernard. Nothing in the antitrust laws prohibits this. *United States v. Colgate & Co.*, 250 U.S. 300 (1919).

brand the blanket license in *Broadcast Music* as *per se* unlawful, this Court stated:

> Finally, we have some doubt—enough to counsel against application of the *per se* rule—about the extent to which this practice threatens the 'central nervous system of the economy', ... that is, competitive pricing as the free market's means of allocating resources. Not all arrangements among actual or potential competitors that have an impact on price are *per se* violations of the Sherman Act or even unreasonable restraints.

441 U.S. at 23 (citation omitted).

In summary there is no basis in the record and no judicial precedent for classifying the contractual agreement between Blue Cross and St. Bernard as the product of a horizontal agreement to fix prices. It is not the type of arrangement which this Court or any other court has heretofore defined as *per se* illegal. Finally, under this Court's analysis in *Broadcast Music*, the contract with St. Bernard was simply ancillary to a lawful objective on the part of Blue Cross to obtain hospital services at the lowest cost for the benefit of Blue Cross policyholders.

II. THE FIFTH CIRCUIT ERRED IN REMANDING THE CASE ON THE BASIS THAT THE EVIDENCE SUPPORTS THE "POSSIBILITY" OF A REFUSAL TO DEAL CLAIM.

Obviously, Blue Cross did not refuse to deal entirely with St. Bernard; it had a contractual relationship with St. Bernard for almost twenty years. The question is whether the St. Bernard contract, considered against the backdrop

of Blue Cross' relationship with the participating hospitals, constituted an unlawful refusal to deal. While the Fifth Circuit, in effect, has held that the evidence supported the "possibility" of a refusal to deal claim under Section 1 of the Sherman Act, the court ignored the unchallenged testimony of the former president of Blue Cross with respect to the reasons why Blue Cross chose to deal with St. Bernard in the manner that it did.

The Fifth Circuit was tentative throughout its opinion. It first stated that the evidence "might indicate" a refusal to deal. 712 F.2d at 987. The court then noted that the district court found that many of the factors necessary to support a *per se* refusal to deal were not present, *e.g.*, that there was no anticompetitive, sinister motive underlying Blue Cross' behavior and that the reimbursement formula was a reasonable plan in the public interest. *Id.* at 988. Although the Fifth Circuit apparently rejected the reasons articulated by the district court for denying the refusal to deal claim, the court did not say why the evidence in the case does not support the findings of the district judge. In effect, the Fifth Circuit simply remanded the case without offering any reasons and without any guidance to the court below as to whether St. Bernard's claim based on a refusal to deal should be judged under a *per se* rule or a rule of reason.

First, in refusing to grant St. Bernard participating status, Blue Cross acted unilaterally. As discussed above, a finding of concerted activity cannot be based solely on the power of appointment to the Blue Cross Board.

There can, as a matter of law, be no claim in this case under Section 1 of the Sherman Act based on a refusal to deal. In a recent Eleventh Circuit case, *Construction*

Aggregate Transport, Inc. v. Florida Rock Industries, Inc., 710 F.2d 752 (11th Cir. 1983), the court analyzed the elements of a concerted refusal to deal:

> First, it is important to remember that a concerted refusal to deal essentially is an agreement among two or more parties that each will engage in an individual refusal to deal with a particular customer or customers. In the case before us, however, we have only one business entity refusing to deal with plaintiff: the ultimate customer of FRI's rock, Basic Asphalt. That FRI may have instigated Basic's refusal to deal does not create the plurality of 'refusals' necessary for the arrangement to be called a group boycott.

710 F.2d at 773; *See also Cascade Cabinet Co. v. Western Cabinet and Millwork, Inc.*, 710 F.2d 1366 (9th Cir. 1983).

In the instant case, there is no "plurality of refusals" because the participating hospitals have never individually dealt with St. Bernard nor would they normally be expected to deal with St. Bernard. The hospitals, as sellers of services, are not on the same market tier as Blue Cross, a purchaser of hospital services. Blue Cross is the only entity who would be expected to deal with St. Bernard. Even the Fifth Circuit recognized the fact that there was a vertical link between St. Bernard and Blue Cross and that the participating hospitals, as suppliers, were on a different market level. 712 F.2d at 986. Under these circumstances, the district court correctly applied a rule of reason analysis to this buyer-seller relationship. *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977); *Muenster Butane, Inc. v. Stewart Co.*, 651 F.2d 292, 295 (5th Cir. 1981); *Red Diamond Supply, Inc. v. Liquid Carbonic Corp.*, 637 F.2d 1001 (5th Cir.), *cert. denied*, 454 U.S. 827 (1981).

Under the rule of reason analysis, the plaintiff must prove that the alleged restriction, on balance, had an adverse effect on competition. *Continental T.V., Inc.*, 433 U.S. at 58-59; *Muenster Butane, Inc.*, 651 F.2d at 295; *Daniels v. All Steel Equipment, Inc.*, 590 F.2d 111, 113 (5th Cir. 1979). The district court found that St. Bernard had failed to carry this burden. The record amply supports this conclusion and it was error for the Fifth Circuit to reverse and remand the case on the basis that the evidence supported the "possibility" of a refusal to deal claim.

III. THE DISMISSAL OF ST. BERNARD'S CLAIM AT THE CLOSE OF PLAINTIFF'S CASE UNDER RULE 41(b) CONSTITUTED A RULING ON THE MERITS.

The dismissal by the district court was a ruling on the merits at the close of plaintiff's case under Fed. R. Civ. P. 41(b). The trial court was empowered under that rule to weigh the evidence, resolve any conflicts, and to decide whether plaintiff had proved its case by a preponderance of the evidence. The trial judge was *not* required to concern himself with whether plaintiff had made out a *prima facie* case. 9 C. Wright & A. Miller, *Federal Practice and Procedure* § 2371, at 224-25 (1971). Conversely, the Fifth Circuit was required to apply the "clearly erroneous" rule and should not have substituted its interpretation of the evidence for that of the trial judge. Fed. R. Civ. P. 52(a).

Although the Fifth Circuit seemed to recognize its mandate at the outset of its opinion, it soon departed from its assigned task. It simply assumed, without any other evidence, that the participating hospitals controlled the affairs of Blue Cross. The Fifth Circuit completely ignored in this regard the uncontradicted testimony of the former

president of Blue Cross. The Fifth Circuit also ignored his testimony concerning the reasons for development of the reimbursement formula in the provider agreement. In effect, the Fifth Circuit treated this case as if it had been dismissed under Rule 12(b) or by way of directed verdict under Rule 50 of the Federal Rules of Civil Procedure. By the time the court got around to ordering a remand, it had lost sight of the role played by the district judge as a finder of fact.

It is submitted that the Fifth Circuit's role was not to determine whether St. Bernard presented sufficient evidence to survive a motion for involuntary dismissal, but rather to determine whether the district court committed an error of law or made factual findings which were clearly erroneous.[6] A finding of fact is clearly erroneous only when "the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed." *United States v. United States Gypsum Co.*, 333 U.S. 364, 395 (1948). As stated above, the Fifth Circuit did not find that the district court's factual analysis was clearly erroneous. Instead, the court chose to remand the case on the erroneous grounds that the evidence presented by St. Bernard "could" add up to one or more theories of an antitrust violation under Section 1 of the Sherman Act.

The Fifth Circuit, having failed to develop an error of law or a basis for holding that the district court's factual finding was clearly erroneous, did not apply the correct

[6] Notwithstanding its clear mandate, the Fifth Circuit stated: "Our role is merely to review whether St. Bernard presented sufficient evidence during the aborted trial to survive a motion for involuntary dismissal." 712 F.2d at 983-984, 988 n. 17.

standard of review. It is respectfully submitted that the Fifth Circuit erred in remanding the case after a Rule 41(b) dismissal simply on the basis that St. Bernard's evidence "could" support a theory of antitrust recovery.

CONCLUSION

After twelve years of litigation, including three appeals to the Fifth Circuit, the reviewing court is still struggling to figure out from plaintiff's pleadings, evidence, briefs and oral arguments just what theory plaintiff hopes to pursue. St. Bernard has had its day in court. St. Bernard's price fixing claim must fall because there is no viable theory under present antitrust doctrine that would render the reimbursement formula in the provider agreement *per se* unlawful solely on the basis of evidence that participating hospitals nominated a simple majority of the persons serving on the Blue Cross Board of Managers. St. Bernard's claim with respect to a refusal to deal must also fall because of the vertical nature of the contractual arrangement, the lack of plurality of agreement to boycott or to refuse to deal with St. Bernard, and the failure of St. Bernard to show any injury to competition.

The evidence in this case shows that Blue Cross, a purchaser of goods and services, acted reasonably in establishing a standard for reimbursement to contracting hospitals under which it would pay 100% of their billed charges for covered benefits, but not to exceed the lesser of the average per diem or the average per case payment made by Blue Cross to the participating hospitals. St. Bernard was the classic illustration of why the reimbursement formula was reasonable and necessary. St. Bernard Hospital was owned and operated by Dr. Bertucci and was admittedly used to subsidize Dr. Bertucci's medical practice and his

clinic. (Supp. Rec., Tr. 122-124, 126, 133, 139, 140, and 191). Without the reimbursement formula, St. Bernard and other contracting hospitals would have had carte blanche to charge Blue Cross for patient care without any obligation to conform to some reasonable standard for the cost of furnishing such goods and services to Blue Cross policyholders. The provider agreement did not establish or fix the price charged by St. Bernard to its patients. It did place a limit on the quantity and the cost of such services to be charged to Blue Cross.

For the above reasons, petitioner respectfully submits that this Petition for Writ of Certiorari should be granted and that after review, the decision of the Court of Appeals should be reversed and the judgment of the district court reinstated.

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APPENDIX "A"

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

NO. 82-3055

ST. BERNARD GENERAL HOSPITAL, INC.,

Plaintiff-Appellant,

versus

HOSPITAL SERVICE ASSOCIATION
of NEW ORLEANS, INC.,

Defendant-Appellee.

Appeal from the United States District Court for the
Eastern District of Louisiana

ON PETITION FOR REHEARING

(October 3, 1982)

Before GEE, GARZA and WILLIAMS, Circuit Judges.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above entitled and numbered cause be and the same is hereby denied.

ENTERED FOR THE COURT:

_____

United States Circuit Judge

APPENDIX "B"

ST. BERNARD GENERAL HOSPITAL, INC.,

Plaintiff-Appellant,

v.

HOSPITAL SERVICE ASSOCIATION OF NEW ORLEANS, INC.,

Defendant-Appellee.

No. 82-3055

United States Court of Appeals,
Fifth Circuit.

Aug. 22, 1983

Hospital brought action against health insurer for violation of antitrust laws. After remand, 510 F.2d 1121, case was dismissed, but the Court of Appeals reversed and remanded, 618 F.2d 1140. Again on remand, the United States District Court for the Eastern District of Louisiana, at New Orleans, Jack M. Gordon, J., ordered involuntary dismissal at the close of plaintiff's case. On appeal by the plaintiff, the Court of Appeals, Jerre S. Williams, Circuit Judge, held that evidence presented at trial established basis of a claim under the first section of the Sherman Act, sufficient to support a treble damage claim under the Clayton Act.

Reversed and remanded.

Gibson Tucker, Jr., Gilbert Andry, New Orleans, La.,

for plaintiff-appellant.

Charles K. Reasonover, Pamela Pryor Mehle, New Orleans, La., for amicus Chalmette, etc.

John A. Stassi, II, New Orleans, La., for amicus St. Charles General.

Jones, Walker, Waechter, Poitevent, Carrere & Denegre, Charles W. Lane, III, New Orleans, La., for defendant-appellee.

Appeal from the United States District Court for the Eastern District of Louisiana.

Before GEE, GARZA and WILLIAMS, Circuit Judges.

JERRE S. WILLIAMS, Circuit Judge.

St. Bernard General Hospital, Inc. (St. Bernard), a small, for-profit hospital in the New Orleans area, brought this antitrust suit claiming restraint of trade by the Hospital Service Association of New Orleans, Inc.,[1] the area Blue Cross licensee. 15 U.S.C. §§ 1, 15. The district court ordered an involuntary dismissal at the close of the plaintiff's case, Fed.R.Civ.P. 41(b). We reverse and remand for futher proceedings.

Procedural History

This is the third appearance of this case before our Court. The case was filed originally in September, 1971.

[1] Hereinafter referred to as HSA or, for clarity's sake, Blue Cross.

In March of 1974, the district court rendered summary judgment in favor of the Blue Cross licensee on the ground that there was no effect on interstate commerce shown in the case. This Circuit reversed and remanded, 510 F.2d 1121 (5th Cir. 1975). On remand, the district court dismissed the suit on the basis of the "business of insurance" exception to the antitrust laws contained in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. This Court again reversed and remanded, 618 F.2d 1140 (5th Cir. 1980), finding that the actions of Blue Cross at question in this case did not fall into the "business of insurance" exception.

While this case was pending, other New Orleans area hospitals filed similar antitrust claims against Blue Cross. These other cases were all consolidated for trial, and discovery was underway at the time of the second remand in this case. St. Bernard moved to consolidate this action with the other cases, but the district court denied the motion both before and at the start of St. Bernard's scheduled trial. Further, the district judge, whose docket included both this case and the other consolidated cases, applied a protective order to much of the discovery in the other cases, so that St. Bernard was not permitted to avail itself of the fruits of discovery in the other consolidated cases.

This case was set for trial on December 21, 1981. On November 4, 1981, the judge held a pretrial conference and found that St. Bernard had not yet completed its preparations for trial or located a key witness. It also had not yet fully informed its opponent of the theoretical underpinnings of its antitrust charges. The judge admonished St. Bernard to complete trial preparations or risk the consequences. The case went to trial as scheduled on December 21.

St. Bernard presented four witnesses at trial: Edmond Vallon, president of Hospital Service Association of New Orleans, Inc. (HSA) during the years in question; Dr. Emile Bertucci, Jr., the chief stockholder and medical director of the hospital; Emile Bertucci, III, an administrator in the hospital toward the end of the years in question; and, Harold Pittman, administrator of the hospital during previous years. These four witnesses testified as to the standard practices of St. Bernard and Blue Cross and the nature of the relationship between the two. No witness testified on the issue of damages, because the parties stipulated before trial that the amount at issue was $147,610.70.

At the end of the plaintiff's case, HSA moved for an involuntary dismissal of the case, pursuant to Rule 41(b), Fed.R.Civ.P. The district court granted the motion, making the following findings:

> No showing of effect on interstate commerce;
>
> Hospital payments in the vast majority of cases would have been the same to St. Bernard regardless of the complained-of conduct, thus negating antitrust injury;
>
> No merit to the substance of the antitrust charges.[2]

St. Bernard appeals from this dismissal. It asks,

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[2] In finding no merit to the substantive antitrust charges, the district court found that there was no sinister or anticompetitive motive on the part of HSA to hurt St. Bernard or impede competition. Furthermore, the court found no scintilla of evidence that there was any economic coercion on the part of HSA, either implicit or explicit. The details of the district court's substantive holdings are discussed later in this opinion.

first, that we find evidence of a per se violation of section one of the Sherman Act under the evidence presented and remand for a full trial, and second, that we grant the earlier-denied motion to consolidate this case with the similar cases now preparing for trial in the same court.

Blue Cross and the New Orleans Hospital Market

We begin by examining the structure of the New Orleans hospital market and the general applicability of the antitrust laws. Blue Cross is a major health care insurer in the country. In New Orleans, the licensee for Blue Cross insures approximately 300,000 people, which is about 38% of those with health care insurance and 30% of the general population. Blue Cross came to the New Orleans area in the 1930's in the form of a private sector, nonprofit corporation founded by four area nonprofit hospitals. These four hospitals referred to themselves as the "participating hospitals." The participating hospitals agreed to run the Blue Cross program on behalf of subscribers and to underwrite any financial shortfalls from operations. Operating surpluses, evidently, were to be rechanneled into Blue Cross programs.

Blue Cross grew and prospered in the succeeding years. Only once were the participating hospitals asked to cover an operating deficit. This was in 1937, when the four participating hospitals collectively covered a $13,000 shortfall. In most years, Blue Cross has enjoyed an operating surplus.

The present suit concerns only the years 1969

through 1972[3]. During the period relevant to this lawsuit, there were nine participating hospitals, all nonprofit facilities in the New Orleans area. The Blue Cross board of directors was composed of 31 members. Each of the nine participating hospitals appointed two representatives to the board, and the remaining thirteen at-large members were elected by the eighteen hospital representatives. In this way, the participating hospitals enjoyed effective control of the Blue Cross board, both by having a simple majority on the board and by selecting all the "outside" directors.[4]

Blue Cross sells hospitalization insurance to individuals and groups under a variety of programs. Some policies pay only basic benefits, while others provide more comprehensive coverage. The basic policies, for example, will not pay for services performed at a hospital without some form of Blue Cross affiliation.[5]

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[3] St. Bernard also claims antitrust injury in the year 1966, but this claim is barred by the statute of limitations. It must also be noted that St. Bernard Hospital is no longer in business. Its successor in operations is the De La Ronde Hospital, also a for-profit facility. The successor hospital is, unlike St. Bernard, a participating hospital in the Blue Cross organization.

[4] The Blue Cross by-laws require that outside directors be subscribers or members of Blue Crosss. This requirement apparently is easy to meet, since Blue Cross underwrites approximately 38% of all health insurance in the area. The record shows that many of the "outside" directors have been not only subscribers to Blue Cross, but board members of the participating hospitals as well, thus effectively strengthening the ties between the participating hospitals and Blue Cross.

[5] Several large employers have negotiated their own Blue Cross master policies, however, containing special provisions. Many of these large-employer policies will provide reimbursement for services performed at non-Blue Cross affiliated hospitals.

The various Blue Cross policies do not reimburse all the area hospitals on an identical basis. Blue Cross distinguishes among three categories of hospitals for reimbursement purposes. At one extreme are the hospitals without any Blue Cross affiliation, known as the "non-affiliated hospitals." These hospitals receive less from Blue Cross under most subscriber policies than an affiliated hospital would receive for identical services. The patient typically is expected to make up the difference, making it less attractive both for the hospital and the patient for Blue Cross members to be treated in non-affiliated hospitals. Non-affiliated hospitals are not involved in the instant case.

At the opposite end of the spectrum are nine affiliated hospitals known as the "participating hospitals." these nine hospitals, which appoint representatives to the board of Blue Cross, are promised reimbursement in full for all care provided to all Blue Cross subscribers, almost without limitation. All nine are nonprofit institutions and are accredited by the Joint Commission on Accreditation of Hospitals (JCAH).

The third group is an intermediate category of affiliated hospitals called "contracting hospitals." Contracting hospitals for the most part are for-profit institutions.[6] Contracting hospitals need not be JCAH-approved. The contracting hospitals have entered into agreements with

[6] Until recently, only nonprofit hospitals could be "participating hospitals" within the Blue Cross system. After this suit was filed, however, Blue Cross offered participating status to additional hospitals, including St. Bernard, a for-profit, contracting hospital. The De La Ronde hospital, the successor institution to St. Bernard, and also a for-profit facility, eventually accepted this invitation and is now a Blue Cross participating hospital. This case, however, involves years when St. Bernard was not accepted as a participating hospital.

Blue Cross, stating that the hospital will provide all needed services to all Blue Cross subscribers desiring admission, without regard to the type of coverage or policy involved. Blue Cross, in return, promises to pay the hospital's usual, customary, and reasonable (UCR) charges.[7]

Unlike the arrangement with the participating hospitals, however, the agreement with the contracting hospitals sets an upper limit on the reimbursable amount. Contracting hospitals are initially paid 100% of the UCR charges, the same reimbursement that Blue Cross would make to a participating hospital. At the end of each year, however, Blue Cross makes an accounting of all hospitalization payments and may demand a partial refund from the contracting hospitals. The contracting hospital may not keep more than the average amount paid to a participating hospital under a like policy for similar illness or a comparable length of stay. Contracting hospitals whose billings do not exceed the average billings of participating hospitals (after adjusting for length of stay, diagnosis, and policy type) owe no rebate to Blue Cross. However, those hospitals whose average charges exceed those of the participating hospitals, after these adjustments, must make a refund of the excess to Blue Cross. Thus, whether a contracting hospital owes a refund to Blue Cross at the end of the year depends on whether that hospital has been able to contain costs at or beneath the average charges of the participating hospitals. There is no comparable refund requirement imposed upon a participating hospital.

During the years in question, 1969-1972, St. Bernard Hospital was one of the Blue Cross contracting hospitals.

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[7] Different policy types, however, provide for different repayment schedules that might affect the actual payment Blue Cross makes to the contracting hospital.

It was a for-profit facility, and was not JCAH approved (although it was fully licensed by the state). It was a 39 bed hospital affiliated with a medical clinic housed in the same building. Dr. Emile Bertucci, Jr., and his family owned the stock of the hospital. Back in 1961, shortly after Dr. Bertucci bought the hospital, St. Bernard entered into its contracting hospital status with Blue Cross. The contract provided for full payment on all types of patient policies, subject to the cap of the average charges of the participating hospitals.[8] In many years, St. Bernard's Blue Cross billings were within the limit imposed, and St. Bernard owed nothing back to Blue Cross. In five of the years, however, St. Bernard exceeded the cap. The first such year was 1966, when St. Bernard refunded $843.04 to Blue Cross. The statute of limitations bars any antitrust claim for 1966. In four later years, 1969-1972, St. Bernard made refunds totaling $147,610.70 to Blue Cross,[9] representing approximately 13 percent of total Blue Cross payments.[10]

It is this refund that is alleged to support the antitrust claims before us. St. Bernard urges that Blue Cross has been favoring the participating hospitals that sit on

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[8] The full payment provision became effective on April 1, 1962. During 1961, Blue Cross paid St. Bernard only 98% of its UCR payments, and in 1960 the figure was 97%. The cap on reimbursement, based on payments to the participating hospitals, has always been in effect.

[9] St. Bernard was not asked to make any Blue Cross rebate during 1967 or 1968. In 1969, it refunded $20,107.04 to Blue Cross. In 1970, it refunded $43,219.34. In 1971, the sum was $33,096.72, and in 1972, $51,187.60. The total for the years in question, 1969-1972, is $147,610.70, as stipulated by the parties.

[10] Blue Cross payments to St. Bernard, which totalled $1,133,476.63 over the four years at issue, constituted approximately one-third of St. Bernard's total income. In 1971, a typical year, 567 of the hospital's 1,588 admissions were Blue Cross cases.

the board at the expense of St. Bernard and the other contracting hospitals. When St. Bernard entered into its agreements with Blue Cross, Blue Cross prohibited St. Bernard from joining as a participating hospital. St. Bernard claims that since Blue Cross would neither offer St. Bernard status as a participation hospital nor reimburse it equally with the participating hospitals, Blue Cross discriminated against it in violation of the antitrust laws. With this overview in mind, we turn to the substance of the antitrust claims in this case.

Sherman Act Applicability

A. Standard of Review

The question before us is not whether there was either in fact or in law an actual violation of the antitrust laws. The question is the more limited one of whether St. Bernard's evidence could support a theory of antitrust recovery if HSA fails to rebut that evidence effectively. We are asked only to decide if the district court's dismissal was proper.

The district court below dismissed this case under Fed.R.Civ.P. 41(b). Rule 41(b) allows a judge to dismiss a case with prejudice at the end of a plaintiff's evidence, if the case is being tried without a jury. In a jury trial, by contrast, the proper motion at the end of the plaintiff's case would be a motion for directed verdict, Fed.R.Civ.P. 50. The standard for granting the motion, hence our standard of review on appeal, differs slightly between the two.

On a motion for directed verdict in a jury trial, the district judge is to look at the evidence in the light most favorable to the nonmoving party, including all reasonable inferences and accepting conflicts in the evidence as

favoring the nonmoving party. Only if the evidence, viewed in that light, fails to establish a legally-cognizable claim is the judge to enter a directed verdict. *Excel Handbag Co. v. Edison Bros. Stores, Inc.*, 630 F.2d 379, 384 (5th Cir.1980).

In a case tried to the court, by contrast, the judge commands the inquiries into facts as well as law. In considering a motion for involuntary dismissal under Rule 41(b), therefore, the district court is not limited to a narrow viewing of the facts, but rather must adjudge the evidence and weigh the credibility of witnesses. *Weissinger v. United States*, 423 F.2d 795, 798 (5th Cir.1970) (en banc). The judge may use his or her skills as factfinder in ruling on the merits of the claims at the close of the plaintiff's case. This is a power denied the judge in a trial where a jury sits as ultimate factfinder.[11]

Since a Rule 41(b) motion permits a judge to consider all inferences, favorable and unfavorable, our standard of review on appeal must differ slightly from that applied to a Rule 50 directed verdict. We must consider not only if the district court erred in the law, but also whether its conclusions of fact are supported by substantial credible evidence and are not clearly erroneous. *Id.* We may not, however, substitute our interpretation of the evidence for that of the district judge. With these standards in mind, we begin by examining the conclusions of the district court.[12]

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[11] A Rule 41(b) motion also differs from a motion to dismiss for failure to state a claim upon which relief can be granted, Fed.R.Civ.P. 12(b)(6), which requires the judge to grant all favorable inferences to the non-moving party.

[12] The district judge erroneously based his Rule 41(b) findings on the standard of a Rule 50 directed verdict; that is, looking at the evidence and the inferences in the light most favorable to St. Bernard. Our disposition of the case today makes this error harmless, however.

B. The District Court's Findings.

1. *Interstate Commerce.*—The district court found no substantial effect on interstate commerce in this case. We reverse this finding. Undisputed evidence in the record shows that St. Bernard purchased much of its supplies from out-of-state suppliers and from out-of-state manufacturers. The economic damage that St. Bernard alleges obviously affected these transactions, whether directly in terms of St. Bernard's ability to purchase supplies or indirectly in terms of its general economic strength and viability. *Hospital Building Co. v. Trustees of Rex Hospital,* 425 U.S. 738, 96 S.Ct. 1848, 48 L.Ed.2d 338 (1976) (hospital's purchase of substantial percentage of supplies from out-of-state is sufficient to support antitrust jurisdiciton).

The Sherman Act's requirement of effect on interstate commerce demands little more than a "not insubstantial" effect on commerce, *McLain v. Real Estate Board of New Orleans, Inc.,* 444 U.S. 232, 246, 100 S.Ct. 502, 511, 62 L.Ed.2d 441 (1980); *Gulf Oil Corp. v. Copp Paving Co.,* 419 U.S. 186, 195, 95 S.Ct. 392, 398, 42 L.Ed.2d 378 (1974), and even an indirect impact by the acts charged upon interstate commerce is not to be tolerated. The commerce requirement of antitrust jurisdiction depends on "the nature of the restraint, and its effect on interstate commerce, and not the amount of the commerce...." *United States v. Central States Theatre Corp.,* 187 F.Supp. 114, 145 (D.Neb.1960). This record establishes that interstate commerce is sufficiently affected to invoke jurisdiction under the antitrust laws. *See also St. Bernard I,* 510 F.2d 1121.

2. *Economic Injury.*—The district court also supported its decision to dismiss on the basis that antitrust injury was not shown. The court reasoned that the evidence showed

that Blue Cross' reimbursements typically would be the same to most hospitals under the most common types of Blue Cross insurance policies. It reasoned that since the vast majority of cases would involve no disparity in payment regardless of the type of relationship between the treating hospital and the Blue Cross organization, St. Bernard could not have suffered antitrust injury.

The district court, however, overlooked the fact that St. Bernard had clearly shown $147,610 in rebates it made to Blue Cross, rebates it would not have had to make if it has been treated on identical terms with the participating hospitals. This figure is undisputed. Regardless of what the "majority" of the Blue Cross reimbursements might have been to St. Bernard or other hospitals, there is no doubt that St. Bernard was treated differently from the "insider" hospitals, to the amount of $147,610. Since an undisputed quantum of damage was shown, we must reverse the district court's finding that there was no disparate economic impact on St. Bernard.

3. *Other Rulings.*—The remaining portions of the district court's findings discuss the substance of the antitrust claims. The district court concluded that Blue Cross' reimbursement structure was a prudent, reasonable regulation with a reasonable relationship to prudent business practice. It found no evidence of any sinister or anticompetitive motive to injure St. Bernard. It found there was not a scintilla of evidence that there was any economic coercion. Since these conclusions go to the substantive merit of the antitrust allegations and require a close examination of both the evidence and the district court's interpretation of the facts, we move to a more detailed discussion of St. Bernard's claims for antitrust relief.

C. Price Fixing Claims.

St. Bernard's evidence, presented in one day and contained in one transcript volume, is relatively simple to describe. It shows that the nine participating hospitals controlled the Blue Cross Board of Directors. It shows that Blue Cross did not deal on identical terms with St. Bernard as a contracting hospital compared to the "insider" participating hospitals. Blue Cross also refused to admit St. Bernard to participating hospital status during the years in question.

These facts could add up to a theory that the participating hospitals, through the medium of the Blue Cross affiliate, combined to inflict financial harm on the other New Orleans hospitals, including St. Bernard. The injury could fall within the part of section 1 of the Sherman Antitrust Act prohibiting combinations in restraint of trade. The plaintiff's precise theory of recovery is neither set forth in the pleadings nor developed at the aborted trial.[13] It could be price fixing, a per se violation of the Sherman Act, price discrimination under the Sherman Act, which is subject to the rule of reason, or other theories of restraint of trade. Also, some claims require a showing of public

[13] We find the pleadings in this case sufficient even though they do not state with particularity the exact proposed theory of relief. Rule 8 of the Federal Rules of Civil Procedure requires only fair notice of the claim. Whether a case is tried to a judge or a jury, federal courts do not insist upon technically precise pleadings. *O'Donnell v. Elgin, J. & E. Ry. Co.*, 338 U.S. 384, 392, 70 S.Ct. 200, 205, 94 L.Ed. 187 (1949). This does not mean that indefinite pleadings are a recommended trial strategy, however. Cases like this one that assert only the barest outline of a claim often will tax the district court and burden the appellate court to "spend a day on the pleadings and the pre-trial order...without coming up with any definite idea of how many claims the plaintiff asserts successively or alternatively." *Plastino v. Mills*, 236 F.2d 32, 34 (9th Cir.1956).

injury, while others require proof of private harm. The failure of St. Bernard to specify the exact nature of its antitrust theory left it to the court to determine not only whether the evidence was enough to "go the distance," but also to measure off the length of the track.

During oral argument on appeal, St. Bernard suggested that price fixing was involved in this case. It relied heavily on *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 102 S.Ct. 2466, 73 L.Ed.2d 48 (1982). The district court in the instant case made its ruling before the *Maricopa* decision was handed down. We examine this recent Supreme Court pronouncement, then, to judge its effect on this appeal.

The *Maricopa* case examined a countywide prepaid health plan operated by a foundation that was run by local physicians. The foundation established maximum prices for doctors' services. Nonmember physicians were free to charge their patients any fee, but the foundation would reimburse only up to the maximum on its posted fee schedule. Member physicians agreed to limit their fees to the maximum on the fee schedule. The district court and the Ninth Circuit held that the case fell under the rule of reason rather than per se principles. These courts reasoned that the pro-competitive and pro-consumer benefits of a centralized cost-containment commission overwhelmed any anticompetitive risks inherent in the broad-based agreement on prices. Relying on *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 99 S.Ct. 1551, 60 L.Ed.2d 1 (1979), they ruled that this case fell outside the per se proscriptions of the antitrust laws since the fixing of prices was only at a superficial level and not in the underlying substance. They held that the Maricopa plan was not "price fixing" in the legal sense but merely the

fixing of a reasonable price schedule.

The Supreme Court reversed. It acknowledged that the foundation's maximum price schedules could serve to benefit consumers and restrain the escalating cost of physicians' services. It also acknowledged that the foundation might not harbor any anticompetitive intent. However, it still condemned the foundation's practices as illegal per se. The Court's justification was not so much the "competitive abuses or evils which those agreements were designed to eliminate or alleviate," 102 S.Ct. at 2474, *quoting United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 218, 60 S.Ct. 811, 842, 84 L.Ed. 1129 (1940), as much as the interests of "business certainty and litigation efficiency." 102 S.Ct. at 2473. The Court realized that the match between presumed and actual anticompetitive effects might be imperfect, but that the imprecision did not warrant the rigors of a full scale judicial inquiry into whether the prices set in each particular case were reasonable or not.

The Court acknowledged the possibility that certain price fixing schemes, perhaps even the Maricopa foundation's, could be beneficial rather than harmful to the public. Yet the opinion declares boldly that pro-competitive justifications are no defense to per se price fixing violations. As stated in *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 224 n. 59, 60 S.Ct. 811, 845, 84 L.Ed. 1129 (1940): "Whatevear economic justification particular price-fixing agreements may be thought to have, the law does not permit an inquiry into their reasonableness. They are all banned because of their actual or potential threat to the central nervous system of the economy."[14]

[14] The Court did suggest, however, that an additional part of its rationale was the fact that it was the doctors themselves setting doctors' fees. It reserved the question of whether a valid cost-containment

The rationale of the majority in *Maricopa* has drawn criticism, both on the Court, 357 U.S. at 457, 102 S.Ct. at 2480 (Powell, Jr. dissenting), and off. Gerhart, *The Supreme Court and Antitrust Analysis: The (Near) Triumph of the Chicago School*, 1982 S.Ct. Rev. 319; Easterbrook, *Maximum Price Fixing*, 48 U.Chi.L.Rev. 886 (1981). It is clear that the refusal of the Supreme Court to look beyond the surface effect of the pricing arrangements and examine instead the underlying competitive effect prohibits potentially beneficial as well as blatantly monopolistic restraints on pricing. The Supreme Court, though, chose to condemn price controls even when beneficial to consumers in the interest of business certainty and judicial economy.

The case before us is not entirely parallel to the *Maricopa* case. The fee schedules in *Maricopa* were strictly a horizontal restraint, created by the local physicians and applicable only to local physicians on the same tier of the supply chain. Horizontal combinations in restraint of trade are well-established to be illegal per se. *See Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 97 S.Ct. 2549, 53 L.Ed.2d 568 (1977). In today's case, by contrast, St. Bernard charges that Blue Cross, as a customer, combined with the participating hospitals, as suppliers, to prejudice St. Bernard's fiscal interests. The charges do not assume a strictly horizontal restraint, but rather include a vertical link from supplier to customer. These charges are not so clearly per se violations of the antitrust laws. *See id.* at 51-57, 97 S.Ct. at 2558-61.

As a further distinction, this case involves the effort

(Footnote 14 continued)
price schedule operated by non-physicians would constitute a per se illegal price fixing scheme. 102 S.Ct. at 2477-78.

of a private health care payor to fix prices, but only as to others. *Maricopa* involved price fixing within its own board but not as to others. In one sense, then, this case merely presents an individual board's announcement of the terms on which it will deal. Nothing in the antitrust laws prohibits an individual trader, absent an anticompetitive intent, from announcing in advance the terms on which he will deal. *United States v. Colgate & Co.*, 250 U.S. 300, 39 S.Ct. 465, 63 L.Ed. 992 (1919). The *Colgate* doctrine, however, is inapplicable here. HSA is not a single trader, but instead is an association comprised of nine local hospitals. St. Bernard charges that the maintenance of disparate pricing schedules was not a unilateral decision on the part of HSA but rather a concerted combination on the part of all nine participating hospitals. A joint effort to fix prices is not protected under the *Colgate* doctrine.

The foundation of doctors in *Maricopa* made no attempt to contain prices to outside, non-member physicians. In today's case, by contrast, HSA has tried to contain prices only as to outsiders and is not limiting reimbursement to its own board members through the cost ceilings. Thus in this sense, this case presents a more egregious scheme of anticompetitive behavior than even *Maricopa*. It imposes burdens on outsiders but not upon the insiders who create the rules.

The *Maricopa* case, due to these dissimilarities, does not control this case. It is possible, even after *Maricopa*, that a pricing schedule could reflect a legal attempt to establish terms of dealing, rather than an illegal price fixing plan. Yet *Maricopa* does, without question, negate the logic employed in the district court here that a price fixing scheme can be legal if its effects further the public interests. Based on the teachings of *Maricopa*, which was

decided after the decision of the district court in ths case, we find that the hospital has made a prima facie showing of a per se price fixing violation. The case must be remanded to the district court for a full and proper consideration of the per se charges and the damages occasioned thereby.

D. Other Antitrust Claims.

The claims in an antitrust case often may fit within more than one theory of antitrust recovery. St. Bernard's contention on appeal seems to be a per se price fixing violation, as discussed above. Its pleadings, however, suggest a generalized allegation under section 1 of the Sherman Act.[15] Without the benefit of more detailed pleadings or the transcript of a full trial to guide us,[16] we cannot be sure that price fixing is the sole section 1 theory St. Bernard intends to pursue. We already have found the price fixing theory substantial enough to justify a remand. Nonetheless, we address possible alternative theories of antitrust relief as additional support for our decision to remand. We begin with a discussion of refusals to deal.

The evidence in this case might indicate a refusal to deal, also a violation of Section 1 of the Sherman Act. Blue Cross, in addition to paying non-identical amounts to participating and contracting hospitals, would not admit St.

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[15] St. Bernard's final amended pleadings in the district court made a simple, categorical assertion of violations of the Sherman Act and the treble damages provision of the Clayton Act. St. Bernard's counsel conceded on oral argument, however, that this case is being pursued only under section 1 of the Sherman Act, prohibiting combinations in unreasonable restraint of trade. Other provisions of the Sherman Act are no longer in issue. There is, notably, no claim of abuse of monopoly or monopsony power under section 2.

[16] The pleadings, nonetheless, are sufficient. *See* note 13, *supra*.

Bernard (and perhaps other hospitals) to participating hospital status. It is clear that Blue Cross was not refusing to deal under any terms with St. Bernard, but it was refusing to deal *on the same terms* as with the nine participating hospitals. A refusal to deal on fair and equal terms can be a prohibited refusal to deal under section 1 of the Sherman Act. *Klor's Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207, 212-13, 79 S.Ct. 705, 709-710, 3 L.Ed.2d 741 (1959); *W. W. Montague & Co. v. Lowry*, 193 U.S. 38, 24 S.Ct. 307, 48 L.Ed. 608 (1904).

Whether a refusal to deal is a per se violation of the Sherman Act or subject to the rule of reason is not always a simple inquiry. Some cases claim that concerted refusals to deal always fall under the per se category. *E.g., Klor's Inc. v. Broadway Hale Stores, Inc., supra.* Other cases, however, clarify the legal analysis and teach that certain factors must be present for a per se analysis to apply. There must be an anticompetitive motive behind the primary purpose of the agreement. *Joseph E. Seagram & Sons, Inc. v. Hawaiian Oke & Liquors, Ltd.*, 416 F.2d 71 (9th Cir.1969), *cert. denied*, 396 U.S. 1062, 90 S.Ct. 752, 24 L.Ed.2d 755 (1970). There must be a commercial purpose to the agreement, rather than, for example, an attempt at industry self-regulation. *United States v. United States Trotting Assn.*, 1960 Trade Cases (CCH) ¶69,761 (S.D.Ohio 1960). *See also United States v. Insurance Board of Cleveland*, 144 F.Supp. 684 (N.D.Ohio 1956) (rules of county association of independent insurance agents subject to rule of reason under group boycott charges). The per se category also requires coercive economic pressure. *Klor's Inc. v. Broadway-Hale Stores, Inc., supra; United States v. New Orleans Insurance Exchange*, 148 F.Supp. 915 (E.D.La.) (J. Skelly Wright, J.), *aff'd*, 355 U.S. 22, 78 S.Ct. 96, 2 L.Ed.2d 66 (1957) (per curiam).

If the requisite factors for a per se refusal to deal violation are not met, the proper course is to examine the conduct under the rule of reason rather than to dismiss the charges completely. *Joseph E. Seagram & Sons, Inc. v. Hawaiian Oke & Liquors, Ltd., supra.* The district court in this case found that many of the factors necessary to support a per se refusal to deal theory were not present. It ruled as part of its Rule 41(b) findings that there was no anticompetitive, sinister motive underlying Blue Cross' behavior. It ruled that the repayment terms furthermore were a reasonable method to protect the public interest and thereby enhance, rather than inhibit, competition.

We have carefully reviewed the evidence in this case and are hard-pressed to define support for the reasons the district court articulated for denying a claim of refusal to deal. The district court found there was no hard evidence of anti-competitive motive. However, the law does not require a "smoking gun" to prove concerted antitrust activity. *Aladdin Oil Co. v. Texaco, Inc.*, 603 F.2d 1107, 1117 (5th Cir.1979). Dr. Bertucci did testify in a deposition read in open court that he did not feel that St. Bernard competed with the other New Orleans area hospitals. Yet the surrounding circumstances of this testimony suggest that Dr. Bertucci was discussing competition only in the marketing or advertising context, and not with regard to formalized antitrust analysis. The district court concluded that there was competition of a sort among area hospitals. Indeed, any other holding would be illogical.

As to the district court's holding that any refusal to deal equally was reasonable, we notice that the prima facie effects of antitrust behavior have been shown. The only readily-apparent escape would be an affirmative defense that the restrictions were reasonable, or were the least

restrictive methods to achieve a legitimate business goal. We cannot make such a finding until the defendant presents its case. Even that evidence, were it to be presented, would of course not counter a per se violation.

We find that the refusal to deal theory also requires remand for a proper disposition. Once again, we offer no opinion on the ultimate merits of the case, as there has not yet been a full trial.[17] We cannot even categorize the nature of St. Bernard's claims as per se violations or rule

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[17] During the years in question, the nonprofit Blue Cross corporation offered the benefits of membership, *i.e.* participating hospital status, only to those hospitals that were organized and operated exclusively for the public benefit as nonprofit organizations. St. Bernard was a for-profit, proprietary hospital. It was organized to make a profit for its shareholders rather than to serve the general public welfare.

The theoretical distinction between for-profit and nonprofit hospitals has blurred in recent years, especially since even nonprofit hospitals do not necessarily have an obligation to provide free charitable care. *See* Rev.Rul. 69-545, 1969-2 Cum. Bull. 117 (hospitals may, under some circumstances, qualify for tax exemptions under I.R.C. §§ 170, 501(c)(3) without providing charitable care); *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26, 96 S.Ct. 1917, 48 L.Ed.2d 450 (1976). Some commentators have questioned whether any distinction between nonprofit and for-profit hospitals continues to be viable. Clark, *Does the Nonprofit Form Fit the Hospital Industry?* 93 Harv.L.Rev. 1416 (1980); Note, *Dissolution of Public Charity Corporations: Preventing Improper Dissolution of Assets*, 59 Texas L.Rev. 1429, 1430-32 (1981). In any event, however, valid legal distinctions between the two types of hospitals still exist, and Blue Cross might have had statutory or policy-based justifications during the years in question for its refusal to offer equal, participating hospital status to St. Bernard.

The record also shows that all nine participating hospitals met the accreditation standards of the JCAH during the years in question. This was a condition of participating hospital status. St. Bernard, by contrast, was not JCAH approved. It was, however, properly licensed by the State of Louisiana. Yet the support in the record for valid reasons Blue Cross might have had to discriminate against St. Bernard is not now a concern of this Court. Our role is merely to review whether St. Bernard presented sufficient evidence during the aborted trial to survive a motion for involuntary dismissal.

of reason determinations under section 1 of the Sherman Act. We have, however, examined the evidence presented to the district court and concluded that undisputed credible evidence supports the possibility of a refusal to deal claim under section 1. This fact is an additional underpinning for our decision to remand this case for further proceedings.

Having found sufficient grounds to remand, we do not consider it appropriate to sift through all the facts of this case to uncover every possible theory of recovery under section 1 of the Sherman Act. We do point out, however, that we do not intend our opinion to foreclose grounds for possible recovery under section 1 that we do not discuss explicitly in this opinion.[18]

Due to the vague nature of the pleadings, we do not know if St. Bernard intends to pursue section 1 theories not covered in today's opinion. We therefore postpone any definitive ruling on whether additional specific theories are supportable in this case, either in law or fact.

Motion to Consolidate

St. Bernard also asks us to review the denial of its motion to consolidate this case with a similar set of actions pending in the same district court. As we mentioned earlier

[18] The facts might, for example, constitute price discrimination. Price discrimination normally falls under the Robinson-Patman Act, 15 U.S.C. §§ 13-13b, 21a, a statute not discussed in the pleadings. Yet price discrimination might also be evidence of a combination that unreasonably restrains trade in violation of the Sherman Act. *See* Trade Reg.Rptr. (CCH) ¶¶3200, 3460 (might constitute Sherman Act violation). *Cf.* L. Sullivan, *Handbook on the Law of Antitrust*, § 220, at 634 (1977) (Robinson-Patman is an analogue to section 2 of the Sherman Act, making no mention of section 1).

in this opinion, four other Blue Cross contracting hospitals in the New Orleans area have filed charges against HSA, presenting similar antitrust allegations based on the same disparate reimbursement formulas involved in the present proceeding. These four other cases have been consolidated for purposes of discovery and trial. St. Bernard moved repeatedly for consolidation with these other cases, and the other plaintiff hospitals, supported the motion. The district court, however, denied this attempt to consolidate the cases.

Consolidating actions in a district court is proper when the cases involve common questions of law and fact, and the district judge finds that it would avoid unnecessary costs or delay. Fed.R.Civ.P. 42; *In re Dearborn Marine Service, Inc.*, 499 F.2d 263, 270-71 (5th Cir.1974), *cert. dism'd*, 423 U.S. 886, 96 S.Ct. 163, 46 L.Ed.2d 118 (1975). Consolidation is improper if it would prejudice the rights of the parties. *Dupont v. Southern Pacific Co.*, 366 F.2d 193, 195-96 (5th Cir.1966), *cert. denied*, 386 U.S. 958, 87 S.Ct. 1027, 18 L.Ed.2d 106 (1967). The district court may order consolidation despite the opposition of the parties. *In re Air Crash Disaster at Florida Everglades on Dec. 19, 1972*, 549 F.2d 1006, 1013 (5th Cir.1977). The fact that a defendant may be involved in one case and not the other is not sufficient to avoid consolidation. *Bottazzi v. Petroleum Helicopters, Inc.*, 664 F.2d 49 (5th Cir.1981). The power of the district court to consolidate is purely discretionary. *Chatham Condominium Assns. v. Century Village, Inc.*, 597 F.2d 1002, 1013-14 (5th Cir.1979).

In the case before us, the district judge gave detailed reasons for his denying the motion to consolidate. Some of the reasons given for the ruling are difficult to accept.[19]

[19] One example is the court's statement that the costs to the

However, the district judge also ruled that consolidation would be improper because the cases were at different stages of preparedness for trial. At the time of his ruling, the St. Bernard case was ready for trial, while the other cases were still in the discovery stages. The delay to the instant action, which already has languished in the federal court system for over a decade, reasonably could have led to the conclusion that this case should be heard separately from from the consolidated cases. *La Chemise Lacoste v. Alligator Co.*, 60 F.R.D. 164, 176 (D.Del.1973); *Transeastern Shipping Corp. v. India Supply Mission*, 53 F.R.D. 204 (S.D.N.Y.1971). *See also* Moore's Federal Practice ¶ 42.02[3].

We cannot say that the denial of consolidation was an abuse of the district court's broad discretion.

We note, however, that our decision today changes the circumstances that affect the question of consolidation. We are remanding for a new trial on the merits, which might be some months away. The four consolidated cases, meanwhile, have proceeded through discovery and are also just a few months away from trial. Because our decision today alters the circumstances surrounding the motion to consolidate, the district court should reconsider the motion to consolidate and rule on whether the interests of judicial economy and fundamental fairness to the parties support consolidation at this time. The decision lies properly in the

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(Footnote 19 continued)
parties would increase if consolidation were allowed. The defendant's costs would likely be lower through consolidation, since it would mean defending only one suit rather than two. Regarding burdens to the plaintiffs in the many cases, another reason noted in the district court, we point out that St. Bernard and the plaintiffs in the other cases are all in support of consolidation.

sound discretion of the district court and not in the Court of Appeals.

Conclusion

We find that the evidence St. Bernard presented at trial establishes the basis of a claim under section 1 of the Sherman Act, sufficient to support a treble damage claim under the Clayton Act. We therefore reverse the imposition of involuntary dismissal under Fed.R.Civ.P. 41(b) and remand for additional proceedings.[20] We find that the denial of the motion to consolidate this claim with similar cases pending in the same district court was not an abuse of discretion at the time, but remand for reconsideration of the motion in light of the changed circumstances stemming, inter alia, from today's opinion.

REVERSED AND REMANDED.

[20] Since the plaintiff has already presented a case in chief, there is no need for a totally new trial unless the cases are consolidated. The plaintiff's case will be part of the record on remand, and the plaintiff need not make a new presentation of its case in chief. *United States v. United States Gypsum Co.*, 333 U.S. 364, 402 & n. 20, 68 S.Ct. 525, 545 & n. 20, 92 L.Ed. 746 (1948). The plaintiff, however, is not limited to that evidence already in the record, and may supplement the record with evidence either in chief or in rebuttal. *White v. Rimrock Tidelands, Inc.*, 414 F.2d 1336, 1340 & n. 7 (5th Cir.1969).

APPENDIX "C"

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA
NEW ORLEANS

ST. BERNARD GENERAL HOSPITAL, INC.
CIVIL ACTION

VERSUS

NO. 71-2493

HOSPITAL SERVICE ASSOCIATION OF
NEW ORLEANS, INC. SECTION "I"

Transcript of EXCERPT OF PROCEEDINGS had in the above-entitled matter, held in the Courtroom, 500 Camp Street, New Orleans, Louisiana, on Monday, December 21, 1981, before the Honorable Jack M. Gordon, District Judge presiding.

BY THE COURT:

There has been in recent years an increased reliance upon the antitrust laws enacted by the Congress in an effort to accomplish what, in this Court's opinion, is a perverse effect of decreasing competition rather than increasing competition. This has been commented on by many learned scholars in various cases. And in this Court's opinion, if this case were allowed to proceed any further, it would be a classic example of just such perversion of our antitrust laws.

We have an instance here where, viewing the evidence in the light most favorable to the plaintiff, giving benefit of all inferences, where the defendant enacted rules to govern maximum reimbursement by private profit-making hospitals so as to limit the opportunities of those

hospitals, either to overcharge or to extend or otherwise do the things that one normally does when the profit motive is in mind.

And I don't mean in any way to suggest that anything is wrong with the profit motive, but it is an incentive. And in viewing it, in this Court's opinion, it is perfectly reasonable, indeed, desirable, if not absolutely necessary, to contain hospital costs by virtue of some limitation, particularly with regard to those whose primary incentive, financial incentive, to be to maximize their own profits.

Thus, to the extent that the rules enacted by Blue Cross as a condition for contract membership by profit-making hospitals, including plaintiff here, could only have had the effect of making those hospitals more competitive with Blue Cross' membership by giving them the incentive to keep, to contain their cost and to provide a greater measure of competition with the major hospitals.

And we now have a situation where those rules, which, in this Court's opinion, could only increase competition, are being cited as antitrust violations.

I find absolutely not a scintilla of evidence that there was any coercion on the part of Blue Cross, implicit or explicit.

Now, one might argue that, as witnesses have speculated about, and only speculated, that if this private hospital did not make it available to Blue Cross, membership, that it would have been deprived of those patients. Well, that might be a reasonable speculation in view of the fact that there were very substantial numbers of Blue

Cross members. But the evidence here is that, with regard to the significant numbers of Blue Cross members, they would have been, that the hospital would have been, paid without regard to whether they had a contract membership, such as those employees who had been employed with large industrial concerns in St. Bernard Parish.

Moreover, the very candid evidence from the plaintiff, Dr. Bertucci, was that his hospital really wasn't even in competition with most of the participating hospitals.

Now, I recognize that there have been many cases around dealing with this subject, and I'm only commenting on this one, around the land dealing with this subject. In my view, if it is prudent, reasonable regulation, it bears a reasonable relationship to prudent business practice; and nothing has been indicated, or nothing has been admitted in evidence to indicate any sinister motive on the part of Blue Cross, any anti-competitive motive, any desire to hurt the plaintiff or to impede competition.

Entirely apart from that, the only evidence which would sustain jurisdiction, as far as effect on commerce was concerned, is entirely speculative, such as that testimony by Mr. Bertucci, the hospital administrator for a part of the time, that since St. Bernard Hospital had under its agreement with Blue Cross the obligation to repay certain excess expenses; that money was not used for the purchase of supplies. When one considers this testimony, which I characterize as rank speculation, with the other testimony and evidence, which indicates a virtual co-mingling of assets, payments, liabilities, expenses, and incomes between Dr. Bertucci's clinic and individual affairs and the hospital, I wonder if it wouldn't be just as easy to speculate that the effect of this payment was to mean less

dollars in Dr. Bertucci's pocket, rather than less effect on commerce.

In other words, I don't believe that the Court can use such speculation to provide the effect on commerce.

So for these reasons, that is, in summarizing, I think the rules of Blue Cross were entirely reasonable, appropriate, and proper; secondly, that, far from impeding competition, they furthered competition; and, lastly, a lack of evidence on the subject matter of jurisdiction of necessary effect on commerce, for all of these reasons, I find that the motion is in order.

And I, therefore, order that judgement for involuntary dismissal under Rule 41(b).

Thank you, gentlemen. Court will stand adjourned.

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